INTERIM STUDY COMMITTEE ON MEDICAID SUPPLEMENTAL PROGRAMS

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MEETING MINUTES[1]

Meeting Date:	**October 6, 2009**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 404**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Rep. William Crawford, Chairperson; Rep. Steve Stemler; Rep. Susan Crouch; Rep. David Frizzell; Sen. Patricia Miller, Vice-Chairperson; Sen. Jean Leising; Sen. Greg Walker; Sen. Sue Errington.**

Members Absent: **Rep. Gail Riecken; Rep. Tim Brown; Sen. Jean Breaux; Sen. Earline Rogers.**

Chairperson Crawford called the meeting to order at 1:05 p.m. Chairperson Crawford told the Committee that he plans to schedule a second Committee meeting later in October because FSSA did not provide timely answers to his questions that were given to FSSA last month until today. Chairperson Crawford requested and encouraged FSSA to work with the Legislative Services Agency (LSA) on the report that LSA is conducting for the Legislative Evaluation and Oversight Subcommittee concerning Medicaid supplemental

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

payment programs (as part of legislation passed during the 2009 session). Chairperson Crawford introduced Committee members and welcomed Representative Charlie Brown to participate in the meeting.

Overview of basic supplemental Medicaid programs

Secretary Anne Murphy, FSSA, introduced FSSA's hospital reimbursement team members: Ms. Pat Casanova, Medicaid Director; Pat Nolting; Doug Elwell; Kristine Ellerbruch; and Keenan Buoy from Myers and Stauffer.

Mr. Doug Elwell, FSSA, provided the Committee with an overview of the following Medicaid programs: the Hospital Care for the Indigent (HCI) program, the Disproportionate Share Hospital (DSH) program, and the Upper Payment Level (UPL) program. See Exhibit 1. Mr. Elwell reported that the HCI program was previously supported by counties through property tax levies but was transferred to the state for administration in the last couple of years to better leverage funds. HCI is a type of UPL payment and HCI went from a claims payment system to an average of claims payment and then back to a claims payment system. Mr. Elwell testified that any remaining funds from the HCI program are distributed to the DSH program or the UPL program, depending on the relevant statute.

Mr. Elwell provided the following information to the Committee concerning the UPL program:

- states may pay up to what Medicare pays for a service
- payments are divided into six categories: in patient state-owned facilities, out patient state-owned facilities; in patient private facilities; out patient private facilities; in patient non state-owned facilities; and out patient non state-owned facilities.
- the UPL program is limited to hospitals that are disproportionate share hospitals for the purpose of providing supplemental payments to these hospitals.
- federal law dictates the eligibility requirements for participation in the UPL program, including a requirement that the facility's Medicaid Inpatient Utilization Rate (MIUR) is one standard deviation above the statewide mean in Medicaid utilization, calculated by taking the hospital's number of Medicaid inpatient days and dividing it by the hospital's total inpatient days.
- Low Income Utilization Rate (LIUR) hospitals, generally psychiatric hospitals, Gary hospital, and Wishard, are not included in calculating the Medicaid utilization mean.
- the UPL program does not provide a capitation on payments for each hospital as long as the costs are within the state Medicaid plan's costs and do not exceed the hospital's charges.

Mr. Elwell informed the Committee that the DSH program has both a state capitation and a per hospital capitation on the amount of payments that can be made under the program. Mr. Elwell said that Indiana has more money in the capitations than Indiana's federal maximum allocation. Mr. Elwell explained that a hospital's capitation is calculated by determining the hospital's total Medicaid costs that exceeded the hospital's Medicaid payments, plus the costs of uninsured care, less any related payments. Mr. Elwell further stated that municipal hospitals receive DSH payments as do Institutions for Mental Diseases. Mr. Elwell informed the Committee that the supplemental payments for Fiscal Years 2006, 2007, and 2008 were paid all at once because FSSA was concerned that the federal government had proposed some rules that would have jeopardized the manner in which Indiana funds its program. See Exhibit 1 for distributions. Mr. Elwell

stated that not all of the 2009 payments have been made to Clarian and Wishard as of this date.

Mr. Elwell described the FY 2007 distribution of payments: HCI payments were made first, UPL pool payments were made second, private hospital payments based on Medicaid days were made third, and the last payments were divided among the historical DSH hospitals based on the number of Medicaid days and the case mix index. Mr. Elwell stated that there was no money left after these payments to distribute to the next pool of hospitals. Mr. Elwell explained that the municipal hospital pool also received money based on the municipal hospital's shortfall.

Mr. Elwell explained to the Committee that FSSA does not review a hospital for eligibility as a DSH hospital every year - the last eligibility period was for the four year period from 2006 through 2009 - and the base years will be changed next year. Mr. Elwell stated that federal law requires the eligibility period to be between two to four years. Mr. Elwell further stated that state law requires that a newly qualified and eligible DSH hospital will receive one third of the hospital's cap in the first eligibility period, two thirds of the hospital's cap in the second eligibility period, and the full cap in the third eligibility period and thereafter. Mr. Elwell indicated that eligibility for the new base period will be based on the hospital's cost report and the current plan is to use the hospital's 2009 cost report for implementation in state FY 2010.

In response to a question about how the additional $5.2 million in federal stimulus money was being distributed, Mr. Elwell responded that the federal Centers for Medicare and Medicaid Services (CMS) had first told FSSA in March, 2009 that it was okay to distribute the money, but CMS recently told FSSA that the stimulus money would have to be used for the Healthy Indiana Plan (HIP). Mr. Elwell further responded that the statutory language for HIP specified that additional funds would be used for the program, but the federal stimulus money was not anticipated at that time and FSSA is continuing to discuss this matter with CMS.

Mr. Elwell commented that both state statute and Indiana's state Medicaid plan set forth the distribution of funds process. Mr. Elwell acknowledged that some of the recent state statute changes were denied by CMS and that the state statute and the state Medicaid plan distribution process differ because of this. When asked whether legislators needed to introduce a bill to change the state statutes to reflect the procedure that has been approved by CMS and that is in the state Medicaid plan, Mr. Elwell responded in the affirmative.

Mr. Tom Fischer, CFO for Community Health Network, stated that the DSH program is a complex program and the program needs to be as transparent as possible. Mr. Fischer reported that it has been difficult for him to obtain information on the program in a timely manner and that there needs to be a flow of information. Mr. Fischer requested that there be full disclosure of calculations and qualifying data for all participants in the Medicaid supplemental payment programs. Mr. Fischer further testified that he did not feel that the one-third, two thirds, three thirds distribution of the capitation for a newly eligible DSH hospital was a good decision. He said that any hospital that meets the DSH eligibility standards should be treated equally and pointed to the dire economic circumstances surrounding hospitals. Mr. Fischer also stated that the four year eligibility period last used by FSSA was too long and that eligibility should be calculated as often as possible. In response to a question as to whether all hospitals should be treated the same in distribution of funds, including historical DSH hospitals, Mr. Fischer replied that he thought all of the hospitals should be treated the same.

Dr. Robin Ledyard, Community Health Network East, stated that she is committed to treating the underserved and stated that Community East will probably qualify as a DSH hospital during the next eligibility period.

Ms. Bernita Drayton, a secretary at Methodist Hospital- Gary and a union member, stated that access to healthcare should be available to everyone and that it is crucial to provide adequate resources to safety net hospitals. Ms. Drayton stated that the current funding levels for safety net hospitals should at least remain the same and the supplemental programs should be maximized to provide as much funding as possible.

FSSA hospital supplemental programs website presentation

Ms. Kristine Ellerbruch, FSSA, demonstrated the new website link that FSSA has developed as a result of legislation enacted in 2009. See Exhibit 2. Ms Ellerbruch stated that the website contains various information on DSH, HCI, and UPL, including payments from recent fiscal years. (http://www.in.gov/fssa/ompp/3961.htm) In response to a question regarding whether the website is currently running, Ms. Ellerbruch responded in the affirmative, although she said there are a couple of links that are not yet active and that FSSA is working to fix these.

Intergovernmental transfers and federal proposed changes

Ms. Casey Kline, Staff Attorney for LSA, provided the Committee with an overview on intergovernmental transfers (IGTs) under the Medicaid program. Ms. Kline summarized a proposed federal rule from 2007 that would have changed the definition of a unit of government for purposes of IGTs and made other changes that would have affected how states conduct IGTs. Ms. Kline informed the Committee that Congress passed a law that placed a moratorium on the proposed rules and that a federal District Court nullified the proposed rules after CMS tried to implement them before the bill with the moratorium was signed by the President of the United States. Ms. Kline stated that the Obama Administration has not attempted to restart the rule making process on these proposed rules. Ms. Kline also provided the Committee with a side by side comparison of the federal health care reform proposals and stated that it was too early to determine how federal health care reform would affect funding of Indiana's DSH program. See Exhibit 3.

Healthy Indiana Plan (HIP)

Ms. Seema Verma, FSSA, provided the Committee with an update on HIP and informed the Committee that the HIP Medicaid waiver application is available on both the DSH website demonstrated at the meeting and the federal CMS website. See Exhibit 4. Ms. Verma informed the Committee that CMS limited the HIP waiver to provide coverage to 34,000 childless adults, and coverage of this population was only allowed because of the DSH funds used for HIP and the cost savings shown in other programs by FSSA. Ms. Verma stated that FSSA closed coverage to childless adults in March, 2009 after the slots for childless adults were full and that 25,000 childless adults are on the HIP waiting list. Ms. Verma informed the Committee that FSSA is getting ready to reopen enrollment in HIP for this population in the next 30 to 45 days since slots are now available, and will contact the first 3,000 to 4,000 childless adults on the waiting list. When asked why FSSA waited so long to reopen these slots, Ms Verma stated that FSSA had to administratively prepare to reopen enrollment and that FSSA stopped enrolling childless adults around the 32,000 person mark so as not to risk going over the 34,000 maximum number.

When asked why more parents were not enrolling in HIP, Ms. Verma acknowledged that she was surprised that more parents were not applying for HIP and

that FSSA has increased advertising to increase awareness of the program. Ms. Verma also cited other possible reasons for low enrollment: that a person is not eligible until the person is uninsured for six months, that there is a contribution required for some people to participate in HIP, and that some people may not see insurance as a priority cost unless they are sick. When asked whether the cigarette tax revenue collected for HIP is kept in a separate account, Ms. Verma stated that the money is kept in a separate account that does not revert back to the state general fund and that FSSA is not using this revenue for any other purpose. The Committee requested that FSSA provide the Committee with the amount of interest that has been accrued on the cigarette tax revenue HIP account. When asked how many people participate in HIP, Ms. Verma stated there are approximately 47,000 individuals enrolled in HIP. Ms. Verma stated that FSSA has requested CMS to approve 7,000 additional slots for HIP and that FSSA used savings in Medicaid pharmacy consolidation to show budget neutrality. Ms Verma testified that FSSA has not received a response from CMS on these additional slots and that the slots were requested in advance of HIP being full because of the amount of time it takes to get approval from CMS.

When asked whether the IBM-ACS modernization project was receiving cigarette tax revenue for making HIP eligibility determinations, Ms. Verma stated that HIP is a separate eligibility determination that is processed by a separate ACS unit and that FSSA pays on a per application basis.

When asked whether disabled individuals are being placed on HIP instead of Medicaid, Ms. Verma stated that a disabled individual may choose to apply for HIP instead of Medicaid because there is no asset limitation test and there is no medical record review under HIP. Ms. Verma stated that FSSA cannot require a person to apply for Medicaid instead of HIP. However, if FSSA knows the individual is disabled and eligible for Medicaid because the individual previously participated in Medicaid spenddown, then FSSA has a duty to act. Ms. Verma further stated that HIP has annual and lifetime coverage limitations that could be quickly exhausted by a disabled individual. The Committee asked that FSSA discuss possible expansion populations for HIP at the next Committee meeting.

Medical Review Team update

Ms. Casanova, FSSA, informed the Committee that FSSA has contracted with a third party vendor to assist FSSA with its medical review backlog and FSSA has hired additional staff for this review as well. Ms. Casanova stated that the backlog of cases under review that were over 90 days old (the federal standard) was down to around 2600 in August, 2009. Ms. Casanova commented that FSSA's goal is to have no backlog of cases over 90 days old by the end of the year. See Exhibit 5.

The meeting was adjourned at 3:35 p.m.